Telephone:
(916) 445-0255

STATE OF CALIFORNIA
Office of the Auditor General
660 J STREET, SUITE 300
SACRAMENTO, CA 95814

Thomas W. Hayes
Auditor General

April 4, 1988

P-578.1

Honorable Bruce Bronzan, Chairman
Members, Joint Legislative
Audit Committee
State Capitol, Room 448
Sacramento, California 95814

Dear Mr. Chairman and Members:

Section 1557 of the Health and Safety Code directs the Office of the Auditor General to report to the Legislature on the Department of Social Services' (department) procedures to minimize the trauma of residents transferred from residential facilities for the elderly and community care facilities when the department temporarily suspends a facility's license. We reviewed the files of 49 facilities to which the department issued a temporary suspension order (TSO) between July 1, 1986, and September 30, 1987. All of the clients in 10 of these facilities had been moved before the TSO was issued. The department believed that the clients in the 5 other facilities had also been moved before the TSO was issued, but we could not confirm this. However, clients were still residing in 34 of the facilities at the time that the department issued the temporary suspension orders. The department notified placement agencies or advocacy groups for clients in 33 of these 34 facilities of the impending TSO. This allowed placement representatives to help the residents relocate, thus, minimizing the transfer trauma involved in changing facilities. Thirteen of 18 placement agencies that we contacted confirmed that the department had worked with them to minimize transfer trauma of residents in facilities to which the department had issued TSOs.

Section 1569.545 of the Health and Safety Code also directs the Office of the Auditor General to report to the Legislature on whether the department consults with physicians and surgeons concerning the immediate removal of residents when the department alleges that the residents are in need of but not receiving proper medical attention. The department alleged that residents at six facilities needed but were not receiving proper medical care. However, in five of these six instances, the department did not consult with physicians and surgeons and did not order the licensees to remove those residents who needed but were not receiving proper medical attention.

Background

In 1973, the California Community Care Facilities Act, (Health and Safety Code, Section 1500 et seq.) established a system for providing residential care for children and adults in need of care and supervision. The intent of the act is to ensure that all of these persons are served by community care facilities that meet established health and safety standards. Community care facilities include any facility maintained and operated to provide nonmedical residential care for children and adults, including but not limited to physically handicapped or mentally impaired persons.

In 1985, the California Residential Care Facilities for the Elderly Act deleted residential care facilities for the elderly from the California Community Care Facilities Act and provided separate licensing and regulation by the department. A residential care facility for the elderly provides group housing and varying levels of care for residents over 60 years of age. Individuals under 60 whose needs are compatible with the other residents may also live in a residential care facility for the elderly.

The department's Community Care Licensing Division regulates both residential care facilities for the elderly and community care facilities. Through its 15 district offices, the department licenses and inspects facilities to ensure that the facilities meet the required health and safety standards. When department staff inspect these facilities, they may cite them for deficiencies, which are violations of state requirements for these care facilities. The licensees must then correct the deficiencies or face possible administrative action, which could include denial of the licensee's renewal application or revocation of a license. In addition, if the department determines that an immediate threat to the health and safety of a facility's residents exists, the department may issue a temporary suspension order, which is an order to immediately suspend the facility's license and to transfer the residents to other facilities.

Placement agencies are responsible for placing children and adults in residential facilities licensed by the department. Placement and advocacy agencies share the responsibility for protecting the interests of these children and adults. The agencies include both public and private entities such as regional centers, county welfare and mental health departments, ombudsman agencies, and adult protective services.

Scope and Methodology

To determine whether the department implemented procedures to reduce the trauma of residents who are transferred from residential facilities for the elderly and from community care facilities, we reviewed the files of 49 of the 78 residential facilities for which the department had issued TSOs between July 1, 1986, and September 30, 1987. Specifically, we determined whether the files contained evidence that the department staff or county staff had obtained resident rosters, whether these rosters contained the names, addresses, and telephone numbers of the placement representatives for residents, and whether the department had notified placement agencies and advocacy groups before the effective date of the TSO. We also interviewed department staff and the staff of placement agencies and advocacy groups.

In addition, we requested that the department give us a list of the facilities having one or more residents who were in need of but not receiving proper medical care. Of the 109 facilities on the department's list, we reviewed the files of 57. To determine whether the department had alleged that a resident was in need of but not receiving proper medical care, we reviewed the files of these facilities for specific allegations that clients were not receiving needed medical care. Since department staff told us that the allegations would be recorded on licensing reports within the files, we considered as an allegation reports detailing a symptom or condition exhibited by the client for which necessary medical treatment was not being provided. In addition, we determined whether the department had consulted with physicians and surgeons regarding the immediate removal of the resident and whether the department had ordered the removal of the resident. Finally, if the department issued a TSO, we determined whether the department had used physicians, surgeons, or other appropriate medical personnel to conduct onsite evaluations of the residents.

Attempts To Reduce Transfer Trauma

Sections 1556(a)(b) and 1569.54(a)(b) of the Health and Safety Code require the department to make every effort to minimize the transfer trauma for the residents of a residential care facility for the elderly or of a community care facility if the department determines that it

should temporarily suspend the license of the facility.* These sections further require the department to contact local agencies that may have placement or advocacy responsibilities for residents of the facility. The department must work with these agencies to locate alternate facilities and to contact relatives responsible for the care of the residents.

In addition, department policy requires the department to obtain a client roster before issuing the TSO. The client roster should have the names of all of the clients in the facility and the names, addresses, and telephone numbers of the placement agencies or authorized representatives for all of the clients. Once the client roster is obtained, department procedures direct the staff to notify each client's placement agency or authorized representative that the department intends to issue an order suspending the license of the client's facility because the immediate health and safety of the client are threatened. Placement representatives then help the clients to relocate, thus reducing the clients' transfer trauma.

Of the 49 facilities that we reviewed and that the department had issued a TSO to, 34 were providing care and supervision to clients at the time that the department served the TSO. However, all of the residents in 10 of the other facilities had been moved from the facilities before the department issued the TSO. Although the department believed that all of the clients had been moved from the remaining 5 facilities, we could not confirm this. The department obtained client rosters from 23 of the 34 facilities that were operating when the TSO was issued. These rosters contained the names, addresses, and telephone numbers of the placement representatives for the clients. After obtaining the rosters, the department notified the placement representatives of the impending TSO for all but one facility. For this one facility, we could not verify that the department notified the placement representatives about the TSO; however, both the department and the adult protective services confirmed that they had worked extensively together before the TSO was issued.

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* According to representatives of the department and of placement agencies, transfer trauma is defined as the stress caused to residents of residential care facilities for the elderly or of community care facilities when the residents must be moved.

The client rosters that the department obtained from 8 of the other facilities that were operating when the TSO was issued did not identify placement representatives because, in some instances, the licensees did not maintain adequate client records. In other instances, the licensees refused to allow department staff access to the client records. However, for the clients of all 8 of these facilities, the department notified placement agencies or advocacy groups of the impending TSO. For example, in the Riverside District Office, the department issued a TSO to a residential care facility for the elderly located in Riverside. Since the licensee's client records did not identify the clients' families or placement representatives, the department notified the long-term care ombudsman and adult protective services in Riverside County. In addition, after the department issued the TSO, a staff person from adult protective services and the department's evaluator went together to the facility to determine whether the clients had been moved. In another instance in the Riverside district office, when the department issued a TSO to a residential care facility for the elderly, department staff were unable to obtain a client roster that identified placement representatives or family members for the residents because the licensees refused to allow the evaluator access to the facility's files. However, the department notified the long-term care ombudsman that the facility would be closed by a TSO.

For the remaining three facilities that were operating when a TSO was issued, the department had no roster. The department did, however, notify advocacy agencies of the impending closure by the TSO.

In 10 of the 49 facilities to which the department issued TSOs, the residents had been moved before the TSO was issued. For example, in the Santa Ana district office, 3 facilities licensed to the same person were closed before the effective date of the TSO. In addition, 3 community care facilities licensed by Santa Cruz, San Bernardino, and Fresno counties had no clients at the time the TSO was issued.

For the 5 remaining facilities from our sample of 49, we could not determine whether the facilities had clients in them when the department issued the TSO. In 3 of the cases, department staff told us that they believed no clients were in these facilities; however, the department took no steps to ascertain that the facilities were, in fact, empty. The department was unable to enter another facility because of the hostility of the licensee and thus was unable to determine whether the facility was operating.

During our review, we contacted 18 placement agencies or advocacy groups to confirm the department's efforts to minimize the trauma to clients in facilities to which the department had issued TSOs. Thirteen of the 18 agencies confirmed that the department had worked with them to minimize the transfer trauma of residents in these facilities. For example, staff at the Alta California Regional Center, a placement agency in Sacramento, told us that the Sacramento district office worked well with their agency when the department issued TSOs to three facilities all licensed to the same couple. A mental health counselor at Sacramento County's adult protective services also told us that the Sacramento district office worked well with her agency to minimize the trauma of individuals who had to be moved to different locations when the three facilities were closed. Before the TSO was actually issued, the department met with representatives of the Alta California Regional Center, adult protective services, Sacramento County Mental Health, and ombudsman's office to discuss the problems at the facilities. In addition, when the department issued the TSO, staff from all five agencies were present at the facilities to help the residents cope with the situation.

In contrast, five placement agencies and advocacy groups indicated that, in their opinion, the department could do more to help them minimize transfer trauma. For example, representatives of the Mental Health Advocacy Project in San Jose and the Public Guardian's Office of Santa Clara County expressed concerns about the San Jose district office's handling of a large facility to which the department had issued a TSO. After substantiating complaints of sexual abuse, the department issued an order suspending the license of a group home in San Jose that was licensed for 48 clients. According to department staff, the department required clients to be moved within 24 hours if they were named in the department's statement of facts and, therefore, could be witnesses against the licensees. However, the housing advocate with the Mental Health Advocacy Project told us that the department's 24-hour requirement was unreasonable. Additionally, according to the supervising deputy public guardian, his office could not successfully find alternate facilities, pack client belongings, and move all their clients within the 24 hours allotted. Nevertheless, since the clients who could provide information regarding the alleged sexual abuse had to be protected, the department's requirement to move them within 24 hours was more important than allowing the clients to remain in the facility longer in order to minimize transfer trauma.

Proper Medical Attention

Sections 1556(c) and 1569.54(c) of the Health and Safety Code describe procedures that the department must follow when it alleges that a client of a residential care facility for the elderly or of a community care facility is in need of but not receiving proper medical attention. These sections require the department to consult with physicians and surgeons about the necessity of immediately removing the client. After this consultation, the department must either order the removal of the resident or, if the department suspends the license of the facility, use physicians and surgeons or other appropriate medical personnel to provide onsite client evaluation.

Since the department has not issued regulations, policies, or procedures that specifically state when and how to implement the requirements stated in Sections 1556(c) and 1569.54(c), we asked the director of the department to provide a list of facilities that the department had alleged as not having provided proper medical care to residents in their facilities. The director gave us a list that she said contained the names of 109 facilities from which department staff "required removal of a client in need of medical care that is beyond the level permitted in community care facilities."

To determine whether the department complied with the statutes, we reviewed the files of 57 of the 109 facilities for specific allegations that clients were in need of but not receiving proper medical attention. However, in 51 of the 57 (89 percent) facility files, either the department did not specifically allege that a client needed but was not receiving proper medical attention or we could not determine whether it had made an allegation. Without knowing whether the department had made an allegation, we could not determine whether clients were in need of medical care, whether they were not receiving medical care, or both. For example, some files contained reports citing facilities for retaining clients who should have been in facilities providing a higher level of medical care. However, the reports provided no evidence that clients needed medical attention. Other files contained reports citing facilities for retaining clients who should have been moved to other facilities because they could not walk without considerable assistance. However, these reports did not allege that the clients were in need of but not receiving medical care.

For the remaining six facilities, the department alleged that the clients needed but were not receiving proper medical attention. For example, at a community care facility, the department identified a

client who was not receiving medication that had been prescribed by a physician. In another instance, the department determined that a client of a residential care facility for the elderly required evaluation "for evidence of infection and to assess physiological responses to immobility." Because the department had alleged that the clients in these six instances needed but were not receiving proper medical attention, the department should have followed the procedures described in Sections 1556(c) and 1569.54(c) of the Health and Safety Code that require consultation with physicians and surgeons. However, the department consulted with physicians or surgeons in only one of these six cases.

When the department does not issue a TSO to a facility in which clients reside who need but are not receiving proper medical attention, the Health and Safety Code requires the department to order the licensee to remove only those clients who need but are not receiving proper medical attention. In all six allegations, the department did not issue TSOs to the facilities. Yet, in only one of these six instances, did the department order the removal of clients who it alleged needed proper medical attention. In the remaining five instances, the department either took no action, ordered the licensee to correct the deficiencies, or ordered the licensee to have a physician examine the client.

If the department fails to consult with physicians and surgeons and orders a licensee to remove a client who the department has alleged needs but is not receiving medical attention, the department may inappropriately require the client's removal from the facility without sufficient evidence that the health and safety of a client is threatened. Conversely, if the department fails to consult with physicians and surgeons and does not order a licensee to remove a client that needs but is not receiving proper medical attention, the client's health and safety are not protected.

According to the deputy director of the department's Community Care Licensing Division, if the department determines that the clients require care in a skilled nursing facility, laws other than Sections 1556(c) or 1569.54(c) of the Health and Safety Code require the department to cite the facility for inappropriate placement and to order the licensee to move clients from the facility. In these cases, according to the deputy director, the department does not have to consult with physicians and surgeons about immediately removing such clients. The deputy director further stated that the department interprets Sections 1556(c) and 1569.54(c) as requiring it to consult with physicians and surgeons only when department staff are unsure

whether a client has life-threatening needs that require medical attention. Moreover, the deputy director told us that the department's legal staff confirms the department's interpretation of the statute, which requires it to consult with physicians and surgeons only when the department is considering ordering the removal of a client or is considering a legal action, such as revoking or temporarily suspending a facility's license.

Although the department's interpretation appears to be borne out by our review of the files that the department provided, the department has not developed written procedures or guidelines that clearly detail this interpretation of the statute.

Conclusion

The Department of Social Services generally minimizes the trauma caused to residents transferred from residential care facilities and community care facilities for the elderly. The department had contacted placement agencies or advocacy groups for clients before issuing an order to temporarily suspend the license of 33 of the 34 facilities that were operating when the TSO was issued. In addition, 13 of 18 placement agencies that we contacted confirmed that the department worked with them to minimize transfer trauma in facilities to which the department had issued TSOs. Further, although we reviewed the files of 57 facilities from the list that the department provided in response to our request for facilities in which the department alleged that clients were in need of but not receiving proper medical attention, we found that the department actually had alleged that clients in only six facilities needed but were not receiving medical attention. The department consulted with physicians or surgeons and ordered the removal of a client in only one of these six cases.

Recommendation

To prevent the inappropriate removal of clients from residential care facilities for the elderly or from community care facilities and to protect the health and safety of clients, the Department of Social Services should specify the circumstances when it should consult with physicians and surgeons and when it should seek appropriate medical personnel to make onsite client evaluations.

We conducted this review under the authority vested in the Auditor General by Section 10500 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

for THOMAS W. HAYES
Auditor General

Department of Social Services' response to this report

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

March 22, 1988

Thomas W. Hayes
Auditor General
Office of the Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Hayes:

Thank you for allowing the Department of Social Services to review and respond to the Office of the Auditor General's draft report entitled "A Review of the Department of Social Services' Implementation of Section 1556 and 1569.54 of the Health and Safety Code Concerning Clients in Residential Care Facilities for the Elderly and in Community Care Facilities" (Audit Control Number P-578.1).

The first section of the report focuses on the Department's actions to reduce transfer trauma of clients when client relocation is necessary. Your report supports actions that the Department has taken to reduce transfer trauma in Temporary Suspension Order (TSO) situations. The Department uses the TSO process only when absolutely necessary to protect clients from an immediate threat and only after a determination that relocation is in the client's best interest. Every effort is made to reduce trauma and we appreciate your recognition of the effectiveness of these efforts.

The second part of the report addresses the Department's actions to notify physicians when clients are in need of, but not receiving, proper medical care. As your report states, the Department's interpretation of the statute differs from that of the Auditor General's staff. The Auditor General's Office interprets the statute to require Community Care Licensing staff to consult with the client's physician anytime a client is not receiving medical attention, whether or not relocation is an issue. If it is not a TSO situation, the Department interprets the statute to require Community Care Licensing staff to notify the client's physician when: (a) trying to determine if a client requires relocation to a medical facility or (b) the client's condition is such that necessity for relocation is obvious. In both situations the Department is trying to avoid or reduce transfer trauma.*

*The Auditor General's comment appears on the next page.

We are in agreement with report findings that formal written procedures are necessary regarding relocation and reduction of transfer trauma when a TSO is not being pursued. We will develop and distribute the procedures to all field staff no later than April 29, 1988.

Thank you again for the opportunity to provide these written comments on your report. We appreciate your efforts in this regard. If you have further questions, please contact me at (916) 445-2077 or have your staff contact Mr. Fred Miller, Deputy Director, Community Care Licensing Division, at (916) 322-8538.

Linda S McMahon

LINDA S. McMAHON
Director

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* Auditor General's Comment: The department's position does not address the key question of when it should consult with physicians and surgeons to determine when a client should be relocated because that client needs but is not receiving proper medical care. Therefore, we have recommended, and the department has agreed to our recommendation, that the department publish written procedures to clarify the circumstances under which physicians and surgeons must be consulted. In developing these procedures, the department should define when a client needs but is not receiving proper medical care.